

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 11976
 County Worcester
 Village or City Endicott (No. 120) St. _____ Ward _____
2 FULL NAME John J. Ayres
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 351

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male **4 COLOR OR RACE** White **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** Married
 (Write the word)

6 DATE OF BIRTH Jan 10, 1840
 (Month) (Day) (Year)

7 AGE 74 10 15 If LESS than 1 day, _____ hrs. OR _____ min. ?
 yrs. mos. ds.

8 OCCUPATION
 (a) Trade, profession, or particular kind of work fish-dealer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Borden Ayres

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Pilchard

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John J. Ayres
 (Address) Salisbury Ind.

15 11/26, 1914, W. F. Smith
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 25, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1914, to Nov 25, 1914,
 that I last saw him alive on Nov 25, 1914.

and that death occurred on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Bright's Disease
 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory Secondary Valvular Disease of the Heart
 (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. L. Oglesby, M. D.
Nov 26, 1914. (Address) Endicott

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Spring Hill Cemetery **DATE OF BURIAL** 26 Nov., 1914

20 UNDERTAKER W. F. Smith **ADDRESS** Snow Hill

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

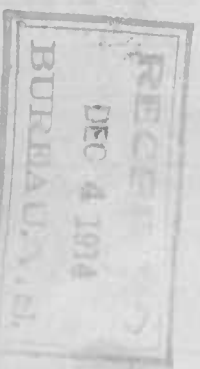
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Garcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 11977

County

Worcester

Village or City

Stockton

(No.

Registration Dist. No.

354

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John J. Besson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

Dec

10

1854

(Month)

(Day)

(Year)

7 AGE

59

yrs

11

mos

8

ds

It LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Cyster Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

Cysterna

9 BIRTHPLACE

(State or country)

New York City

PARENTS

10 NAME OF FATHER

Jacob. Besson

11 BIRTHPLACE OF FATHER (State or country)

New Jersey

12 MAIDEN NAME OF MOTHER

Sarah C. Bunker

13 BIRTHPLACE OF MOTHER (State or country)

New Jersey

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jas B Besson

(Address)

Stockton Md

15

Filed

11/9/14

1914

W O Payne

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

November 8th

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Oct 14th

1914

to

Nov 8th

1914

that I last saw him alive on Nov 8th, 1914

and that death occurred on the date stated above, at 9-30 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

John D. Dickerson, M. D.

11/9/14

1914

(Address)

Stockton Md

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

It not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Stockton Presbyterian

11/10, 1914

20 UNDERTAKER

ADDRESS

Hancock & Smack

Stockton Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

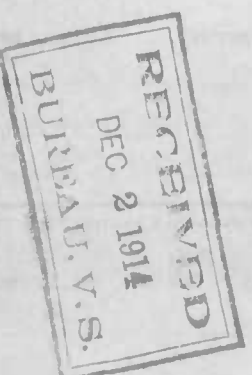
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 11978
 County Worcester
 Village or City Snow Hill (No. 5) St.; Ward)
2 FULL NAME Baby Blake

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 351

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)
6 DATE OF BIRTH <u>Nov. 7, 1914</u> (Month) (Day) (Year)		
7 AGE <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. OR <u>1</u> day, <u>0</u> hrs. <u>0</u> min. ?		8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>✓</u>
9 BIRTHPLACE (State or country) <u>Worcester, Co.</u>		
PARENTS	10 NAME OF FATHER <u>John Rowley</u>	11 BIRTHPLACE OF FATHER (State or country) <u>Worcester Co.</u>
	12 MAIDEN NAME OF MOTHER <u>Mary Blake</u>	13 BIRTHPLACE OF MOTHER (State or country) <u>Snow Hill</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nancy C. Parker
 (Address) Girdle Tree Rd

15 Filed 11/8, 1914 L. L. Roy Smith
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 351

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 7, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____
 that I last saw h_____ alive on _____, 191____
 and that death occurred on the date stated above, at _____ m.
 The CAUSE OF DEATH* was as follows:
Still Born
no Physician
 (Duration) _____ yrs. _____ mos. _____ ds.
 Contributory _____
 Secondary _____
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) L. L. Roy Smith L. Reg. M. D.
11/8, 1914 (Address) Snow Hill.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
 if not at place of death? _____

Former or
 usual residence _____

19 PLACE OF BURIAL OR REMOVAL <u>Int. Wesley</u>	DATE OF BURIAL <u>Nov 8</u> , 191 <u>4</u>
20 UNDERTAKER <u>Levin Martin</u>	ADDRESS <u>Snow Hill</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestive," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Worcester 11979STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 351Village or City Girdletrus (No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mildred E. Brittingham

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

✓

6 DATE OF BIRTH

June 13, 1914
(Month) (Day) (Year)

7 AGE

4 yrs. 5 mos. 7 ds. OR 1 day, 5 hrs. 7 min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

John R. Brittingham

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Viola M. Taylor

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. R. Brittingham

(Address)

Girdletrus Md.

15

Filed 11/21, 1914L. L. Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 19, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Nov 14, 1914 to Nov 19, 1914that I last saw him alive on Nov 18, 1914and that death occurred on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronch)(Duration) _____ yrs. _____ mos. 4 ds.Contributory
SecondaryEnter Colitis(Duration) _____ yrs. _____ mos. 7 ds.

(Signed)

J. C. Ogden

, M. D.

Nov 21, 1914 (Address) Girdletrus Md.

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bethesda ChurchyardNov. 21, 1914

20 UNDERTAKER

ADDRESS

W. F. Heam Snow Hill

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

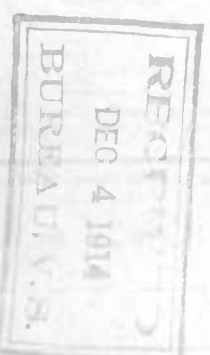
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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent death state means of injury and qualify as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH Worcester 11980 151
 County Worcester
 Village or City Snow Hill (No. _____, _____ St.; _____ Ward)
 2 FULL NAME No name Chandler
 Registration Dist. No. 351
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Nov 15, 1914
 (Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. 5 ds. OR _____ min. ?
 If LESS than 1 day, _____ hrs.

8 OCCUPATION
 (a) Trade, profession, or particular kind of work ✓
 (b) General nature of industry, business, or establishment in which employed (or employer) ✓

9 BIRTHPLACE (State or country) Maryland

PARENTS
 10 NAME OF FATHER Joshua Chandler
 11 BIRTHPLACE OF FATHER (State or country) Delaware
 12 MAIDEN NAME OF MOTHER Henrietta Johnson
 13 BIRTHPLACE OF MOTHER (State or country) Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Joshua Chandler
 (Address) Snow Hill R.F.D.

15 Filed 11/20, 1914 4 LeRoy Smith
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 20, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,
 that I last saw him _____ alive on _____, 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

No physician
sick from pink. &
waking
 (Duration) _____ yrs. _____ mos. 5 ds.

Contributory
 Secondary

(Signed) Rue Jones M. D.
Nov 20, 1914 (Address) Snow Hill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. to the State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted, If not at place of death? _____
 Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL W. Church Cemetery DATE OF BURIAL Nov 21, 1914
 20 UNDERTAKER Marion Dickerson ADDRESS Snow Hill Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

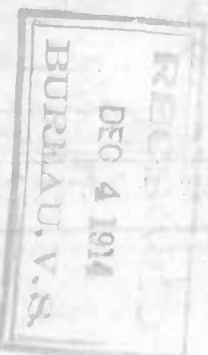
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word, or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Furn laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, *septicæmia*," "PUERPERAL, *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

11981

County WorcesterSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 351Village or City Girdletown md (No. 1)

St.: _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Hillie Collic

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH

July 6, 1903
Month Day Year

7 AGE

11 yrs. 4 mos. 10 ds.

If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Girdletown md

PARENTS

10 NAME OF FATHER

John Collic

11 BIRTHPLACE OF FATHER

(State or country)

Worcester Co md

12 MAIDEN NAME OF MOTHER

Hattie Rowley

13 BIRTHPLACE OF MOTHER

(State or country)

Worcester Co md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Norace. Harmon

(Address)

Girdletown md

15

Filed 11/16, 1914V. L. Boy Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 14, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Nov 6, 1914, to 14, 1914.that I last saw him alive on Nov 14, 1914.and that death occurred on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Refractive of Bowel with Peritonitis
compensating tubercular lesion(Duration) _____ yrs. _____ mos. 28 ds.Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. C. O. G. G. G., M. D.Nov 16, 1914. (Address) Girdletown md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Scorpion CemeteryNov 16, 1914

20 UNDERTAKER

ADDRESS

H. S. WilliamsDonothell md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

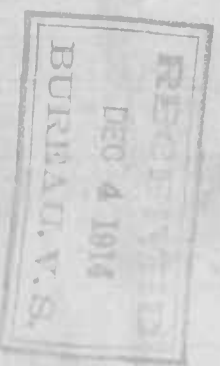
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and QUALITY as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on Statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Worcester Co.

11982

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 355

Village or City Berlin (No. _____, St. _____ Ward _____)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME No name Dirickson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Girl 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) X

6 DATE OF BIRTH Nov 24, 1914
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Worcester Co Md

10 NAME OF FATHER Henry Dirickson

11 BIRTHPLACE OF FATHER (State or country) Worcester Co

12 MAIDEN NAME OF MOTHER Rosa Hammond

13 BIRTHPLACE OF MOTHER (State or country) Worcester Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Dirickson

(Address) Berlin Md

15 Filed Nov. 25, 1914 W. H. Hecoway
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 24, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw him _____ alive on _____, 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Dead Born

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
Secondary _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. H. Hecoway, M. D.
Nov 25, 1914 (Address) Berlin Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL St Pauls Cemetery DATE OF BURIAL Nov 24, 1914

20 UNDERTAKER J. W. Burbage & Co ADDRESS Berlin Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

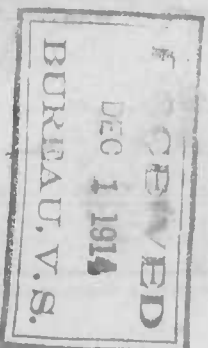
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic adicular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH Norwalk 11983 (24)
 County Norwalk
 Village or City Berlin (No. md) St. Ward
 2 FULL NAME James Thomas Ellis
 Registration Dist. No. 355
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
 6 DATE OF BIRTH Oct. 30, 1914 (Month) (Day) (Year)
 7 AGE 24 yrs. 24 mos. 24 ds. OR min. ? If LESS than 1 day, hrs.
 8 OCCUPATION (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 9 BIRTHPLACE (State or country) Maryland
 10 NAME OF FATHER Carrie Ellis
 11 BIRTHPLACE OF FATHER (State or country) Maryland
 12 MAIDEN NAME OF MOTHER Edith Wooden
 13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Corrie Ellis(Address) Berlin md

15 Nov 23, 1914 W. H. Hannon
 Filed Nov 23, 1914 W. H. Hannon
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 22, 1914 (Month) (Day) (Year)
 17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1914, to Nov 22, 1914, that I last saw him alive on Nov 22, 1914, and that death occurred on the date stated above, at 4 P. m.
 The CAUSE OF DEATH* was as follows:
Tetanus
 (Duration) 10 yrs. 10 mos. 10 ds.
 Contributory Secondary
 (Signed) E. H. Holloway, M. D.
Nov 23, 1914 (Address) Berlin md
 *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
 Where was disease contracted, If not at place of death?
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Friendship Church DATE OF BURIAL Nov 23, 1914
 20 UNDERTAKER J. W. Burbo ADDRESS Berlin md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Scille," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
DEC 1 1914
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 11984 **64**
 County Howard
 Village or City Williams (No. _____, _____ St.; _____ Ward)
2 FULL NAME Amenda J. Evans
 STATE OF MARYLAND
 CERTIFICATE OF DEATH
 Registration Dist. No. 350
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE white
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 (Write the word)
6 DATE OF BIRTH Sept 2nd, 1869
 (Month) (Day) (Year)
7 AGE 75 yrs. 2 mos. 18 ds. OR LESS than 1 day, _____ hrs. _____ min. ?
8 OCCUPATION
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
9 BIRTHPLACE (State or country) Md.

PARENTS

10 NAME OF FATHER Franklin Caney
11 BIRTHPLACE OF FATHER (State or country) Md
12 MAIDEN NAME OF MOTHER Nancy D. Miller
13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. J. Evans
 (Address) Rt 4 Towson City

15 Filed 11/21, 1914 G. H. Williams
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 20th, 1914
 (Month) (Day) (Year)
17 I HEREBY CERTIFY, That I attended deceased from Nov. 20th, 1914 to Nov. 20th, 1914
 that I last saw him alive on Nov. 20th, 1914
 and that death occurred on the date stated above, at 7 A. m.
 The CAUSE OF DEATH* was as follows:

Sudden collapse
 (Duration) _____ yrs. _____ mos. _____ ds.
 Contributory Cerebral hemorrhage
 Secondary Emphysema
 (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Wilson, M. D.
Nov. 20th, 1914 (Address) Towson City

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted, If not at place of death?
 Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Presbyterian Cemetery **DATE OF BURIAL** 11/22, 1914
20 UNDERTAKER Stetson & Son **ADDRESS** Pecanoke

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

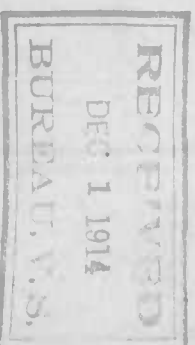
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Worcester</u>		11985 (28)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Showell</u> (No. _____)		St.; _____		Ward _____	
2 FULL NAME <u>Eliza J. Freeman</u>		[It death occurred in a hospital or institution, give its NAME instead of street and number.]			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)			
6 DATE OF BIRTH <u>Oct. 10, 1863</u> (Month) (Day) (Year)					
7 AGE <u>51</u> yrs. <u>1</u> mos. <u>2</u> ds.		It LESS than 1 day, _____ hrs. OR _____ min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Del.</u>					
PARENTS	10 NAME OF FATHER <u>Litton Brasine</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Del.</u>				
	12 MAIDEN NAME OF MOTHER <u>Mary Grace</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Del.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Levi J. Freeman</u> (Address) <u>Showell, Md.</u>					
15 FILED <u>Nov. 14, 1914</u> <u>W. L. Holloway</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Nov. 12, 1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>899</u> to <u>Nov. 12, 1914</u> that I last saw him alive on <u>Nov. 12, 1914</u> and that death occurred on the date stated above, at <u>10</u> p. m. The CAUSE OF DEATH* was as follows: <u>Tuberculosis of Lungs</u> (Duration) <u>15</u> yrs. _____ mos. _____ ds.					
Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>Rollin P. Greenup</u> , M. D. <u>Nov. 13, 1914</u> (Address) <u>Bishopville</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Ebenezer Cemetery</u>					DATE OF BURIAL <u>Nov. 14, 1914</u>
20 UNDERTAKER <u>P. F. Watson</u>					ADDRESS <u>Sellyville Del.</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

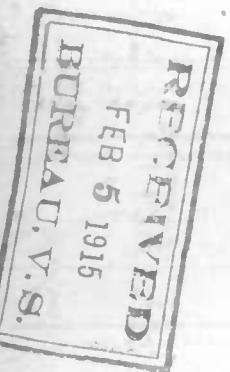
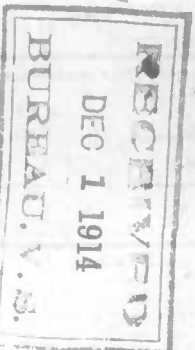
Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Team laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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Don't and
to be signed
on this
form.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Worcester</u>		11988 (91)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Shomlee</u>		(No. _____)		Registration Dist. No. <u>355</u>	
2 FULL NAME <u>May Hall</u>		St.; _____		Ward) _____ [It death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Col.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u>			
6 DATE OF BIRTH <u>Aug 2</u> , 191 <u>4</u> (Month) (Day) (Year)		16 DATE OF DEATH <u>Nov. 16</u> , 191 <u>4</u> (Month) (Day) (Year)			
7 AGE <u>3</u> yrs. <u>16</u> mos. <u>16</u> ds. If LESS than 1 day, ____ hrs. OR ____ min. ?		17 I HEREBY CERTIFY, That I attended deceased from <u>Nov. 16</u> , 191 <u>4</u> , to <u>Nov. 16</u> , 191 <u>4</u> that I last saw her alive on <u>Nov. 16</u> , 191 <u>4</u> and that death occurred on the date stated above, at <u>11:40 P.m.</u> The CAUSE OF DEATH* was as follows: <u>Broncho pneumonia</u>			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>none</u>		Contributory (Secondary) <u>Marasmus</u> (Duration) ____ yrs. ____ mos. <u>7</u> ds.			
9 BIRTHPLACE (State or country) <u>Maryland</u>		(Signed) <u>J. R. Bishop</u> , M. D. <u>11/17</u> , 191 <u>4</u> (Address) <u>Shomlee Md.</u>			
PARENTS	10 NAME OF FATHER <u>John S. Hall</u>	State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>	18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____			
	12 MAIDEN NAME OF MOTHER <u>Ella Shomlee</u>	19 PLACE OF BURIAL OR REMOVAL <u>Hall Cemetery</u> DATE OF BURIAL <u>Nov 17</u> , 191 <u>4</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>	20 UNDERTAKER <u>P. F. Watson</u> ADDRESS <u>Silbyville</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Jos. P. Hall</u> (Address) <u>Shomlee Md</u>					
15 Filed <u>Nov 17</u> , 191 <u>4</u> <u>W. L. Kucoway</u> REGISTRAR					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

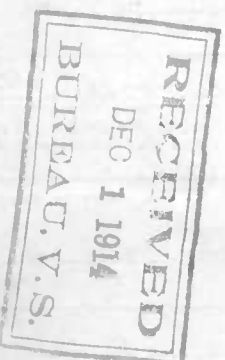
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

11987

County

Charles Co.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 200

Village or City

Berea RFD

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

no name

Hastings

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 SINGLE,
MARRIED,
WIDDED,
ORDIVORCED
(Write the word)

6 DATE OF BIRTH

Nov 8, 1914
(Month) (Day) (Year)

7 AGE

yrs. mos. ds. OR min. ?

If LESS than
1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF
FATHER

Geo Hastings

11 BIRTHPLACE
OF FATHER
(State or country)

Maryland

12 MAIDEN NAME
OF MOTHER

Mary Jarvis

13 BIRTHPLACE
OF MOTHER
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Hastings

(Address)

Berea Rd RFD

15

Filed

Nov 8, 1914 W L Quonway
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 8, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

1914 to Nov 8, 1914

that I last saw him alive on 1914

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

10 weeks Foster

Contributory
Secondary

(Duration) yrs. mos. ds.

Lifted heavy weight

(Signed)

E. J. Holland

(Duration) yrs. mos. ds.

Nov 8, 1914 (Address) Berea

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

None

Nov 8, 1914

20 UNDERTAKER

ADDRESS

None

Berea Rd

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

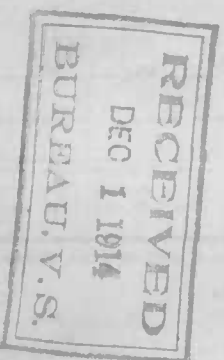
[Approved by U. S. Census and American Public Health Association.]

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oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH Worcester 11988 157 **STATE OF MARYLAND**
County Worcester **CERTIFICATE OF DEATH**
Registration Dist. No. 353
Village or City Ocean City **No.** md **St.;** **Ward**
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME not named Hastings

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u></u>
6 DATE OF BIRTH <u>Oct. 21</u> , 191 <u>4</u> (Month) (Day) (Year)		
7 AGE <u>—</u> yrs. <u>—</u> mos. <u>15</u> ds. OR <u>—</u> min. ?		If LESS than 1 day, <u>—</u> hrs.
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>—</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u>		
9 BIRTHPLACE (State or country) <u>Worcester Co.</u>		
PARENTS	10 NAME OF FATHER <u>Ernest Hastings</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Worcester Co.</u>	
	12 MAIDEN NAME OF MOTHER <u>Elisha Dukes</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Worcester Co.</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sherry Hastings
 (Address) Ocean City, Md.

15 Filed Nov-4, 1914 Gas H. Mumford
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 4, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
Oct 21, 1914 to Nov 4, 1914
 that I last saw her alive on Nov 4, 1914
 and that death occurred on the date stated above, at — m.
 The CAUSE OF DEATH* was as follows:
Pneumonia
 (Duration) — yrs. — mos. 15 ds.
 Contributory Pneumonia
 Secondary (Duration) — yrs. — mos. 2 ds.
 (Signed) J. R. Bishop, M. D.
1114, 1914 (Address) Stineel, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, It not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL <u>Essex Green Cemetery</u>	DATE OF BURIAL <u>Nov 5</u> , 191 <u>4</u>
20 UNDERTAKER <u>J. W. Burboye & Co.</u>	ADDRESS <u>Boston, Md.</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

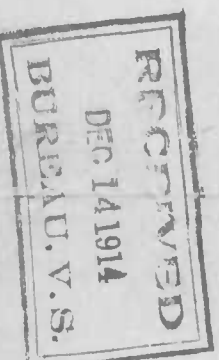
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, STUPIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

11989

40

County ProsserSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 351Village or City Snow Hill (No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Alfred J. Haubert

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Feb211857

(Month)

(Day)

(Year)

7 AGE

57810ds.

If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Former & dependent

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Frederic Haubert

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Biddle

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alvin Haubert

(Address)

Broad Street Station Phila Pa

15

Filed 11/5, 1914Re Roy Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov13th1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1914, to Nov 13th, 1914.that I last saw him alive on Nov 14th, 1914.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Cancer of StomachContributory
Secondary(Duration) 1 yr. 10 mos. 10 ds.

(Signed)

Mr. H. H.

(Address)

Paul Jones, M. D.Shoreville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

W. P. County Snow Hill Box 5, 1914

20 UNDERTAKER

ADDRESS

W. P. Hean Snow Hill

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

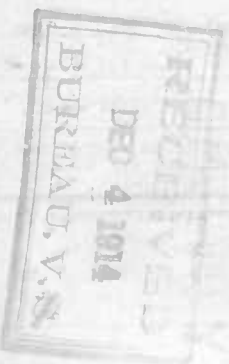
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH <i>Worcester</i>		11990		28		STATE OF MARYLAND CERTIFICATE OF DEATH	
County		No.		Registration Dist. No.		350	
Village or City		No.		St.:		Ward)	
2 FULL NAME		<i>Ella A. Long</i>					
PERSONAL AND STATISTICAL PARTICULARS							
3 SEX <i>Female</i>	4 COLOR OR RACE <i>Colored</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Married</i>					
6 DATE OF BIRTH <i>June 15, 1876</i>							
7 AGE <i>38 yrs 5 mos 4 ds.</i>		If LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		<i>General House work</i>					
9 BIRTHPLACE (State or country)		<i>Worcester Co. Md.</i>					
PARENTS	10 NAME OF FATHER	<i>Daniel Gansford</i>					
	11 BIRTHPLACE OF FATHER (State or country)	<i>Worcester Co. Md.</i>					
	12 MAIDEN NAME OF MOTHER	<i>Jane Fleming</i>					
	13 BIRTHPLACE OF MOTHER (State or country)	<i>Worcester Co. Md.</i>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE							
(Informant)		<i>John Ed Long - husband</i>					
(Address)		<i>Pocomoke City Md.</i>					
15 Filed	<i>11/22, 1914</i>						
16 REGISTRAR		<i>Ephraim Hellman</i>					
MEDICAL CERTIFICATE OF DEATH							
16 DATE OF DEATH		<i>Nov 19, 1914</i>					
17 I HEREBY CERTIFY, That I attended deceased from		<i>March 20, 1914, to Nov 19, 1914</i>					
that I last saw <i>her</i> alive on		<i>Nov 18, 1914</i>					
and that death occurred on the date stated above, at		<i>9:30 a.m.</i>					
The CAUSE OF DEATH* was as follows:		<i>Tuberculosis of Lungs</i>					
(Duration)		<i>23 yrs. mos. ds.</i>					
Contributory							
Secondary							
(Signed)		<i>W. C. Sartorius, M. D.</i>					
Nov 19, 1914		(Address) <i>Pocomoke City</i>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.							
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)							
At place of death		yrs. mos. ds.		In the State		yrs. mos. ds.	
Where was disease contracted, if not at place of death?							
Former or usual residence							
19 PLACE OF BURIAL OR REMOVAL				DATE OF BURIAL			
<i>Halls Hill No 1</i>				<i>11/22, 1914</i>			
20 UNDERTAKER				ADDRESS			
<i>Charles Ballard</i>				<i>Pocomoke</i>			

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

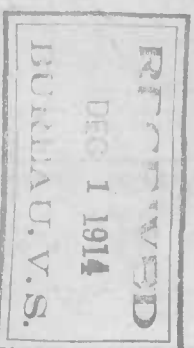
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1 PLACE OF DEATH

11991

47

County WorcesterSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 355Village or City Campbell

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mrs. Jane Murray

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Widowed

6 DATE OF BIRTH

Jan 8, 1837
(Month) (Day) (Year)

7 AGE

76 yrs. 9 mos. 29 ds.
If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Delaware

PARENTS

10 NAME OF FATHER

Thomas T. Rodgers11 BIRTHPLACE OF FATHER
(State or country)Maryland

12 MAIDEN NAME OF MOTHER

Hannah Latham13 BIRTHPLACE OF MOTHER
(State or country)Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Maggie Davis

(Address)

Silbyville Del

15

Filed

Nov. 20, 1914J. W. Haddon

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

November 18, 1914
(Month) (Day) (Year)

17

HEREBY CERTIFY, That I attended deceased from

11/11/14, 191, to 11/17/14, 191,that I last saw h. or alive on 11/17/14, 191.and that death occurred on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) yrs. mos. 6 ds.Contributory Aortic regurgitation.
(Secondary)(Duration) yrs. 7 mos. ds.

(Signed)

J. P. Bishop

, M. D.

11/18/1914 (Address) Showell, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oddfellows CemNov 20, 1914

20 UNDERTAKER

ADDRESS

P. F. WatsonSilbyville Del.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

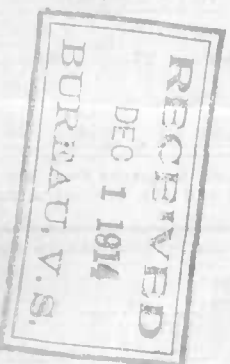
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1 PLACE OF DEATH		11992		STATE OF MARYLAND	
County <u>Worcester</u>		(90)		CERTIFICATE OF DEATH	
Village or City <u>Snow Hill</u>		(No. _____)		Registration Dist. No. <u>351</u>	
2 FULL NAME <u>Geo. W. Parsons</u>				[If death occurred in a hospital or institution, give its NAME instead of street and number.]	

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>11</u> <u>1st</u> , 191 <u>4</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>April 27</u> , 18 <u>41</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended deceased from <u>October 20</u> , 191 <u>4</u> , to <u>Nov. 1st</u> , 191 <u>4</u> , that I last saw him alive on <u>Nov. 1st</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>2 o'clock P.</u> m.		
7 AGE <u>73</u> yrs. <u>6</u> mos. <u>4</u> ds. OR <u>1</u> day, <u>1</u> hrs. <u>0</u> min. ?			The CAUSE OF DEATH* was as follows: <u>Acute Bronchitis</u>		
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____			(Duration) _____ yrs. _____ mos. <u>10</u> ds.		
9 BIRTHPLACE (State or country) <u>Maryland</u>			Contributory <u>Tuberculosis</u> Secondary _____		
PARENTS	10 NAME OF FATHER <u>Thos. P. Parsons</u>	(Duration) <u>2</u> yrs. _____ mos. _____ ds.			
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>	(Signed) <u>John S. Deloite</u> , M. D.			
	12 MAIDEN NAME OF MOTHER <u>Sallie B. Davis</u>	<u>Nov. 3</u> , 191 <u>4</u> . (Address) <u>Snow Hill Md.</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>	*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Geo. W. Parsons</u> (Address) <u>Snow Hill, P. O. #1</u>			18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____		
15 Filed <u>11/3</u> , 191 <u>4</u> <u>LeRoy Smith</u> REGISTRAR			19 PLACE OF BURIAL OR REMOVAL <u>McEbandy Snow Hill P. O. #3</u> , 191 <u>4</u> DATE OF BURIAL _____		
			20 UNDERTAKER <u>W. T. Hearn</u> ADDRESS <u>Snow Hill</u>		

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affliction need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misarrriage as "Puerperal septichæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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¹ PLACE OF DEATH 11993 28
County Worcester

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 354

Village or City Woburne (No. _____, St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME Lloyd Washington Payne

PERSONAL AND STATISTICAL PARTICULARS

³ SEX Male ⁴ COLOR OR RACE White ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the words)

⁶ DATE OF BIRTH January 28, 1891
(Month) (Day) (Year)

⁷ AGE 23 yrs. 9 mos. 7 ds. OR 1 day, 0 hrs. 0 min. ?
If LESS than 1 day, hrs. min. ?

⁸ OCCUPATION
(a) Trade, profession, or particular kind of work Telephone Lineman
(b) General nature of industry, business, or establishment in which employed (or employer) Telephone Co

⁹ BIRTHPLACE (State or country) Maryland

PARENTS
¹⁰ NAME OF FATHER Lloyd Payne
¹¹ BIRTHPLACE OF FATHER (State or country) Maryland
¹² MAIDEN NAME OF MOTHER M. Ellen Gilet
¹³ BIRTHPLACE OF MOTHER (State or country) Maryland

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lloyd Payne
(Address) Woburne, Md.

¹⁵ Filed 11/57, 1914 W O Payne
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH Nov. 4, 1914
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1914, to Nov. 3, 1914.

that I last saw him alive on Nov. 3, 1914.

and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) 1 yrs. 6 mos. 0 ds.

Contributory
Secondary

(Signed) John L. Dickerson, M. D.
Nov. 5, 1914 (Address) Stockton, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

¹⁹ PLACE OF BURIAL OR REMOVAL Benson & Co. Cemetery 11/6, 1914
DATE OF BURIAL

²⁰ UNDERTAKER Hancock & Snodgrass Stockton, Md.
ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

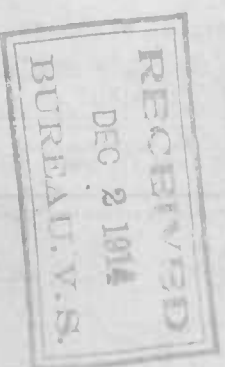
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not faithfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 11994
County Worcester

Village or City Near Snow Hill Md (No. _____)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 351

St.; _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Price

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH _____

(Month) _____ (Day) _____ (Year) _____

7 AGE about 1 month exactly, between 80 & 90 If LESS than 1 day, _____ hrs. _____ min. ?
yrs. _____ mos. _____ ds. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

House wife
Home

9 BIRTHPLACE (State or country)

Worcester Co Md

PARENTS

10 NAME OF FATHER

don't no

11 BIRTHPLACE OF FATHER (State or country)

don't no

12 MAIDEN NAME OF MOTHER

Jennie Borden

13 BIRTHPLACE OF MOTHER (State or country)

Worcester Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles H. Dale

(Address)

Snow Hill Md

15

Filed

11/29, 1914 W. L. Roy Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 27th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.

that I last saw him alive on _____, 191____.

and that death occurred on the date stated above, at 3 o'clock a.m.

The CAUSE OF DEATH* was as follows:

Physician
Cardiac Asthma

(Duration) 2 yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Nov 28, 1914 (Address) Snow Hill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Taylor Gate Cemetery Nov 29, 1914

20 UNDERTAKER

ADDRESS

St. S. Williams Snow Hill Md

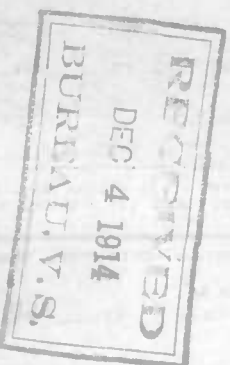
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tracema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent death state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 11995

County

Worcester

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 354

Village or City

Wellbourne

(No. 40)

St.:

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Annie Punell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7 AGE

35

yrs.

mos.

ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

House wife

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

John Dennis

11 BIRTHPLACE OF FATHER
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Ellen Holmes

13 BIRTHPLACE OF MOTHER
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Roberts

(Address)

Wellbourne, Md.

15

Filed

11/22

1914

W. O. Payne

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov

22

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 19

1914

to

Nov. 19

1914

that I last saw her alive on Nov. 19, 1914

and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(Duration) yrs. 12 mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

John R. Dickerson, M. D.

Nov. 22

1914

(Address)

Stockton, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery

11/24, 1914

20 UNDERTAKER

ADDRESS

Herant Coe Ingram New Orleans, La.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

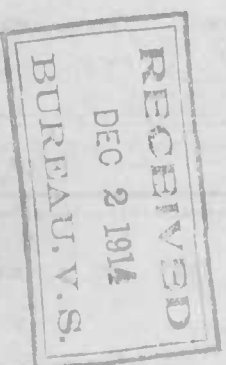
[Approved by U. S. Census and American Public Health Association.]

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 1896 186

County WorcesterVillage or City Berlin (No. 700) St. Wd. Ward 3552 FULL NAME Evelyn PurnellSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 355

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Cal 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) —

6 DATE OF BIRTH March 23, 1914
(Month) (Day) (Year)

7 AGE — yrs. 7 mos. 12 ds. OR 1 day, — hrs. — min. ?
It LESS than 1 day, — hrs. — min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Berlin

PARENTS
10 NAME OF FATHER John Purnell
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Klarame Smith
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Purnell(Address) Berlin Md

15 Filed Nov 4, 1914 W. L. Falloway
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 3, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from — 191— to — 191—,

that I last saw him — alive on —, 191—and that death occurred on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Ind Dr
(Duration) — yrs. — mos. — ds.

Contributory
Secondary — (Duration) — yrs. — mos. — ds.

(Signed) W. L. Falloway, M. D.
Nov 4, 1914 (Address) Berlin Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL Permanence Cem DATE OF BURIAL Nov 4, 1914

20 UNDERTAKER J. W. Burbage ADDRESS Berlin Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

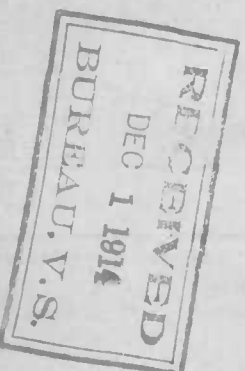
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Worcester Md

11987 186

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 355Village or City Berlin (No. _____, St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Thatcher Purnell Infant

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Nov 21, 1914
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. 1 ds. OR _____ min. ?
If LESS than 1 day, _____ hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Charles Paris

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Thatcher Purnell

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lillie Mary Gray(Address) Berlin Md

15 Nov 23, 1914
Filed _____, 1914 W. H. Hecceway

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 22, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 1914, to _____, 1914,

that I last saw him alive on Nov 22, 1914

and that death occurred on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

no Dr attendanceLeuris J. Evans undertaker

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Lucia Mary Gray M. D.Nov 23, 1914 (Address) Berlin Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Berlin Md

DATE OF BURIAL

Nov 23, 1914

20 UNDERTAKER

Leuris J. Evans Berlin Md

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

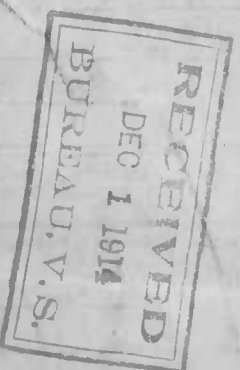
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH		STATE OF MARYLAND	
County <u>Worcester</u> 11998 <u>64</u>		CERTIFICATE OF DEATH	
Village or City <u>Pawmoke</u> (No. _____) St; _____ Ward _____		Registered No. <u>350</u>	
2 FULL NAME <u>Arthur Schoofeld Quinn</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>single</u> (Write the word)	
6 DATE OF BIRTH <u>Dec. 29</u> , 18 <u>71</u> (Month) (Day) (Year)			
7 AGE <u>42</u> yrs. <u>10</u> mos. <u>10</u> ds.		If LESS than 1 day, _____ hrs. OR _____ min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Printer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____			
9 BIRTHPLACE (State or country) <u>Worcester Co</u>			
PARENTS	10 NAME OF FATHER <u>Samuel S Quinn</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Pawmoke city</u>		
	12 MAIDEN NAME OF MOTHER <u>Amanda J Conner</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Worcester Co</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Samuel S Quinn</u> (Address) <u>Pawmoke city</u>			
15 Filled <u>11/7</u> , 191 <u>4</u> <u>Edman Hillman</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Nov 7</u> , 191 <u>4</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on <u>Nov 7</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>4 P</u> m. The CAUSE OF DEATH* was as follows: <u>Apoplexy</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory (Secondary) <u>8 hours</u> (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>Samuel S Quinn</u> , M. D. <u>11/7</u> , 191 <u>4</u> (Address) <u>Pawmoke city</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Wesleyan</u>		DATE OF BURIAL <u>11/9</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Clemonson Bros</u>		ADDRESS <u>Pawmoke</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

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RECEIVED
DEC 1 1914
BUREAU, V. S.

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1 PLACE OF DEATH Worcester 11999
 County Worcester
 Village or City Berlin md (No. 40) St.; Ward)
 2 FULL NAME John L Rayne

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 355

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, married
 WIDOWED, OR DIVORCED
 (Write the word)

6 DATE OF BIRTH March 16, 1823
 (Month) (Day) (Year)

7 AGE 41 yrs. 7 mos. 29 ds. OR 1 day, 1 hrs. 1 min. ?
 If LESS than 1 day, hrs. min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer) Dealer in carriages & so

9 BIRTHPLACE (State or country) Maryland

PARENTS
 10 NAME OF FATHER John Rayne
 11 BIRTHPLACE OF FATHER (State or country) Maryland
 12 MAIDEN NAME OF MOTHER Rose Gorman
 13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Rayne
 (Address) Berlin md

15 Filed Nov 17, 1914 W. L. Hecox
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 14, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May, 1913 to Nov 14, 1914.
 that I last saw h in alive on Nov 14, 1914

and that death occurred on the date stated above, at 5:45 P. m.
 The CAUSE OF DEATH* was as follows:

Cancer of the Intestine
 (Duration) 1 yrs. 6 mos. 0 ds.

Contributory Exhaustion
 Secondary (Duration) 0 yrs. 0 mos. 0 ds.

(Signed) W. L. Hecox, M. D.
Nov 14, 1914 (Address) Berlin md

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.
 Where was disease contracted, If not at place of death?
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Berlin md DATE OF BURIAL Nov 17, 1914
 20 UNDERTAKER Curtis J. Evans ADDRESS Berlin md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

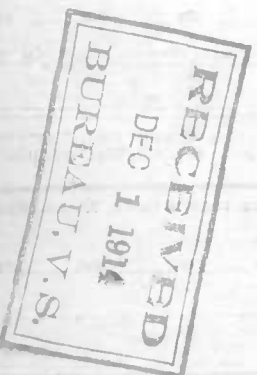
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1 PLACE OF DEATH County <u>Worcester</u>		12000		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Near Zion M. E. Church</u>		St. <u>7</u> Ward		Registered No. <u>951</u>	
2 FULL NAME <u>Cora Shoemaker</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Anglo-Saxon</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> <small>(Write the word)</small>			
6 DATE OF BIRTH <u>No record.</u>		(Month) (Day) (Year)			
7 AGE <u>About 35 yrs.</u>		If LESS than 1 day, hrs. OR min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Worcester Co., Md.</u>					
PARENTS	10 NAME OF FATHER <u>George Hieghman</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>				
	12 MAIDEN NAME OF MOTHER <u>Cora Brinkley</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Worcester Co., Md.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Geo. W. Livingstone</u> (Address) <u>Near Zion M. E. Church, Md.</u>					
15 Filed <u>11/15</u> , 191 <u>4</u> <u>LeRoy Smith</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Nov 14</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Nov 5</u> , 191 <u>4</u> , to <u>Nov 15</u> , 191 <u>4</u> , that I last saw her alive on <u>Nov 15</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>3 P. m.</u> The CAUSE OF DEATH* was as follows: <u>Typhoid Fever</u> (Duration) <u>about</u> yrs. <u>14</u> ds.					
Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) <u>Jos. P. McLaughlin, M. D.</u> <u>Nov 15, 1914</u> (Address) <u>Fruitland Md.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Near Zion M. E. Church, Worcester Co.</u>				DATE OF BURIAL <u>Nov 16th</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Geo. C. Hill</u>				ADDRESS <u>Salisbury Md.</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

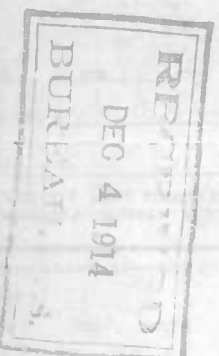
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the illness CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congestive," "Sedative" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

12001

County

Worcester

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

351

Village or City

Snow Hill

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

P. Sidney Smith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Feb

29

1898

(Month)

(Day)

(Year)

7 AGE

52

yrs.

9

mos.

17

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Turks Island West Indies

PARENTS

10 NAME OF FATHER

B. Everett Smith

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Elizabeth Hayward

13 BIRTHPLACE OF MOTHER

(State or country)

Turks Island West Indies

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. P. Sidney Smith

(Address)

Washington D. C.

15

Filed

11/15

1914

L. Roy Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 13

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

11:30 a.m., Nov 12, 1914, to 12:50 a.m., Nov 13, 1914.

that I last saw him alive on Nov 13, 1914.

and that death occurred on the date stated above, at 12:50 a.m.

The CAUSE OF DEATH* was as follows:

acute dilatation of heart

(Duration)

1 hr - 20 minutes

Contributory Secondary

Violent exercise

(Duration)

yrs. mos. ds.

(Signed)

Nov 14, 1914

(Address)

Saw Jones, M. D.
Snow Hill Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Snow Hill

Nov 15

1914

20 UNDERTAKER

ADDRESS

W. T. Hearn Snow Hill

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is unnecessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH		12002		STATE OF MARYLAND	
County <u>Worcester</u>		(64)		CERTIFICATE OF DEATH	
Village or City <u>Snow Hill Md</u>		(No.)		Registration Dist. No. <u>351</u>	
2 FULL NAME <u>Georgiana S. Wilson</u>				[If death occurred in a hospital or institution, give its NAME instead of street and number.]	

PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Female</u>	4 COLOR OR RACE <u>colored</u>	5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) <u>Married</u>		16 DATE OF DEATH <u>Nov 30</u> , 191 <u>4</u> (Month) (Day) (Year)	
6 DATE OF BIRTH <u>Jan 24</u> , 18 <u>49</u> (Month) (Day) (Year)		7 AGE <u>65</u> yrs. <u>11</u> mos. <u>24</u> ds. If LESS than 1 day, hrs. OR min. ?		17 I HEREBY CERTIFY, That I attended deceased from <u>Nov 26</u> , 191 <u>4</u> , to <u>Nov 29</u> , 191 <u>4</u> , that I last saw her alive on <u>Nov 29</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>9 9</u> m. The CAUSE OF DEATH* was as follows: <u>Paraplegia</u>	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>House Wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Same</u>		9 BIRTHPLACE (State or country) <u>Worcester Co Md</u>		Contributory Secondary (Duration) yrs. mos. <u>2</u> ds.	
10 NAME OF FATHER <u>Wm H. Jones</u>		11 BIRTHPLACE OF FATHER (State or country) <u>Worcester Co Md</u>		(Signed) <u>John L. Riley</u> , M. D. <u>Nov 30</u> , 191 <u>4</u> (Address) <u>Snow Hill Md</u>	
12 MAIDEN NAME OF MOTHER <u>Georgiana Jones</u>		13 BIRTHPLACE OF MOTHER (State or country) <u>Worcester Co Md</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Ola. Wilson</u> (Address) <u>Snow Hill Md</u>				18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence	
15 Filed <u>11/30</u> , 191 <u>4</u> <u>LeRoy Smith</u> REGISTRAR		19 PLACE OF BURIAL OR REMOVAL <u>Ebenezer Cemetery</u>		DATE OF BURIAL <u>Dec 2</u> , 191 <u>4</u>	
		20 UNDERTAKER <u>H. S. Williams</u>		ADDRESS <u>Snow Hill Md</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

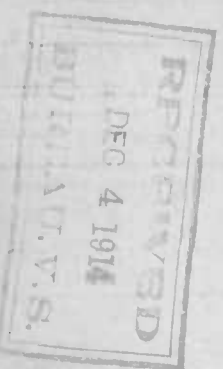
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Huntton," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Worcester 12003 186STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 350Village or City Near Pocomoke (No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Raymond Garfield Wise

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

colored5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Single

6 DATE OF BIRTH

April 14, 1914
(Month) (Day) (Year)

7 AGE

7 yrs. 7 mos. 7 ds. OR 1 day, 7 hrs. 7 min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

md

PARENTS

10 NAME OF FATHER

David Wise

11 BIRTHPLACE OF FATHER

(State or country)

md

12 MAIDEN NAME OF MOTHER

Addie Lounn

13 BIRTHPLACE OF MOTHER

(State or country)

md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

David Wise

(Address)

Pocomoke RFD Route 4

15

Filed 7/11, 1914Ephraim Hillman

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 16, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Nov 16, 1914, to Nov 16, 1914that I last saw him alive on Nov 16, 1914and that death occurred on the date stated above, at 3:00 p. m.

The CAUSE OF DEATH* was as follows:

Sudden Collapse(Duration) 3 yrs. 3 mos. 3 ds.Contributory
SecondaryInfluenza Pneumonia(Duration) 3 yrs. 3 mos. 3 ds.

(Signed)

J. M. Wilson, Coroner, Physician, M. D.

(Address)

Nov 16, 1914 (Address) Pocomoke City

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 7 yrs. 7 mos. 7 ds. In the State 7 yrs. 7 mos. 7 ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Hells Hill Rd.

DATE OF BURIAL

11/12, 1914

20 UNDERTAKER

Chas Ballard

ADDRESS

Pocomoke

I

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

